St.Vincent's Medical Center

7/31/18 POC accepted CMD

July 31, 2018

Cheryl A. Davis, RN, B.S.N.
Supervising Nurse Consultant
State of Connecticut, Department of Public Health
Facility Licensing and Investigations Section
410 Capitol Avenue, MS#12HSR
Hartford, CT 06134-0308

RE: Violation letter dated July 20, 2018
Dates of visits December 5 & 6, 2017 and May 7 & 8, 2018

Dear Ms. Davis:

This letter is in response to your letter dated July 20, 2018 to Dawn Rudolph, President and CEO of St. Vincent's Medical Center, concluding on May 8, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Please note that the violation letter is addressed with a plan of correction attached.

Sincerely,

Dale Danowski
Senior Vice President, Chief Nursing Officer

DD/emf

St. Vincent's Medical Center Response to DPH July 31, 2018

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (4)(A) and/or (i) General (6).

1. **Based on a review of clinical records, interviews and policy review, for one (1) of twenty (20) records reviewed for emergency room care and services (Patient # 1), the hospital failed to ensure that the on-call hand surgeon evaluated the patient when s/he presented to the ED with a left traumatic 3rd digit amputation through the middle phalanx and concomitant injuries to the 2nd and 4th digits. The finding includes the following:
    a. Patient #1, a 72 years-old presented to the ED on 4/22/18 at 7:32 PM via EMS after sustaining an injury while using a table saw. The patient had a past medical history of diabetes, coronary artery disease, hypertension and myocardial infarction. Review of MD #1's assessment dated 4/22/18 at 7:28 PM indicated that the patient was working with a table saw when a piece of wood threw the blade back and took the distal phalanx of his/her third finger and tips of the 2nd and 4th fingers. The lacerations were jagged in nature and bone was exposed on digits 2-4. Review of the radiological report dated 4/22/18 at 8:12 PM identified that there were amputation deformities of the distal second and third digits with absence of the distal phalanx of the third digit as well as the tuft of the distal second phalanx. There is probable involvement of the distal tip of the middle third phalanx. The distal interphalangeal joint (DIP) of the third digit is disrupted.

       Review of MD # 1's progress note at 8:17 PM reflected that an emergent consult to the on-call hand surgeon, MD #2, was made, the case was described and MD #2 advised MD #1 to call hospital #2 for transfer for consideration of re-implantation as MD #2 does not perform re-implants. The note further reflected that MD #1 called hospital #2 and spoke with MD #3 about the case. MD #2 and MD #3 discussed the case and per MD #2, MD #3 would evaluate the patient. The patient was subsequently transferred to hospital #2 at 9:44 PM for evaluation of the traumatic hand injury.

       Review of the clinical record from hospital #2 dated 4/22/18 identified that the patient was transferred from hospital #1 after a table saw injury with amputation of the left 3rd finger and damage to the 2nd and 4th. The ED physician evaluated the patient at 10:37 PM and requested a plastic surgery consult. Consultation identified that the patient was evaluated and given the mechanism of injury, zone of injury, and patient's significant comorbidities, replantation versus revision amputation were explained to the patient ultimately pursuing revision amputation. The patient subsequently had the wound closed in the ED and no re implantation based on the risks and benefits reviewed. The patient was discharged home on 4/23/18 at approximately 3:10 AM.

       Interview with MD #1 on 5/7/18 at 1:30 PM stated his main goals were to get a plan to address the patient's fingers, pain control and obtain baseline bloodwork. Upon the

patient's arrival to the ED, he called the on-call hand surgeon MD #2, who indicated that the patient should be transferred since she does not do re-implantations. MD #1 stated that when he spoke with the potential receiving physician (MD #3), he stated MD #2 should see and evaluate the patient prior to transfer and this could be a case ofEMTALA. After speaking to MD #3, MD #1 called MD #2 again who felt that comingin to evaluate the patient would delay the process and felt this was not an EMTALA asthe patient was being transferred to a higher level of care. The patient was subsequently transferred to acute carc hospital #2 on 4/22/18 at 9:44 PM.

Interview with MD #2 on 5/8/18 at 8:30 AM verified that she was called on 4/22/18 about a patient who had a distal phalanx amputation. MD #2 indicated she felt that thepatient should be evaluated for microsurgery and this was not performed at the facility.MD #2 stated she reviewed a picture of the patient's hand sent to her and that she did notcome into the ED to evaluate patient as this would delay potential treatment. MD #2 further stated that the receiving hospital indicated they would not refuse the patient however did request that she evaluate the patient and review options, risks and benefits.MD #2 indicated that she responded to the call, however, did not go to the ED to evaluate the patient as she felt that would delay the care.

Review of the clinical record lacked documentation that identified Patient # 1 was evaluated by MD #2, the on-call hand surgeon, despite MD #1's and the receiving hospital's request to do so.

Review of the EMTALA policy indicated that the on-call physician must come to theED when requested by the ED physician, another physician, a nurse or any hospital worker making the request on behalf of the physician or nurse. If requested, the on-call physician must come to the ED to see a patient that is being transferred to another institution before the transfer and must communicate with the receiving physician.
Review of the facility Rules and Regulations indicated that Consultations shall show evidence of the consultations review of the patient's record, pertinent findings on examinations of the patient and the consultant's opinion and recommendations.

#1 a	
1.	*Measure to prevent the recurrence of the identified violation.* *I. Plan for correcting deficiency:* *a. Initiate a Focused Professional Practice Evaluation ("FPPE") on MD#2* *b. Chairperson Surgery to review all ED consults by MD#2 for next six months (June-Dec 2018) for documentation of a timely and accurate assessment in compliance with our policies and procedures.* *II. Plan for improving processes that led to deficiency cited, including how the hospital is addressing improvements in its system to prevent the likelihood of recurrence of the deficient process:* *a. Communication of "On-Call Expectations" to all medical staff at next Quarterly Medical Staff Meeting* *b. Re-education of all On-Call and ED Providers on EMTALA requirements including process for escalation of potential violations according to regulatory provisions and organizational policies and procedures.* *c. EMTALA Administrative Policy (600-33) was reviewed-no revisions needed* *d. ED Nurse Manager will review EMTALA policy and expectations with ED Charge Nurses* *e. Conduct chart audits (25 per month to include transfers from ED and ED consultation requests to the On-Call services) to ensure providers' compliance with On-Call expectations and the organizational EMTALA policy.* *f. Ensure follow up by responsible Department Chairpersons on any identified gaps in compliance by On-call providers*
2.	*Date corrective measure will be effected.* *I a. FPPE communicated-June 14, 2018* *II b. FPPE initiated 6/14/18 and monitoring will be ongoing until 12/31/18* *II a. Communication:* • *Chief Clinical Officer met with Chairpersons June 11, 2018* • *Medical Executive Committee June 12, 2018* • *Quarterly Medical Staff meeting June 19, 2018* • *ED Chairman meeting with ED Providers June 22, 2018* *II b. Re-education of providers launched June 18, 2018 with written attestation of receipt and understanding to be returned by June 30, 2018* *II c. Policy reviewed June 6, 2018-no revisions needed* *II d. ED Charge Nurse meeting-June 19, 2018* *II e. Chart Audits initiated June 18, 2018; ongoing review until Sept 1, 2018*
3.	*Identify the plan to monitor corrective measure(s) or systemic change(s) to ensure that the improvement(s) are sustained.* *I a. MD #2-Chart Audits on all ED Consults by Chairperson of Surgery for six months*

	II. e. Emergency Department Chairperson and/or designee to conduct 25 chart audits per month for six months of ED encounters where a request for consultation with a specialist was made by an ED provider. Audit will be focused on compliance with the appropriate and timely assessment and documentation by the consultant in accordance with our policies and procedures and current regulatory compliance provisions.
4.	***Individual responsible for monitoring:*** • ***Chief Clinical Officer***

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-03 (b) Administration (2) and/or (c) Medical Staff (2) and/or (4) (A) and/or (e) Nursing Services (1) and/or *(f)* Diagnostic and therapeutic facilities and/or (i) General (6).

2. Based on observations, facility documentation and interviews the hospital failed to ensure infection control practices were maintained. The findings include:
   a. During tour of the operating room (O.R.) suite on 11/28/17 it was identified that two staff personnel in O.R room 6 had failed to cover their entire head allowing hair to beexposed at the back and sides during a procedure. Review of the Surgical Attire policyidentified hair shall be covered with a lint free-free surgical cap/hood.
   b. During tour of the O.R. suite on 11/28/17 it was identified two O.R. tables which had recently been cleaned revealed multiple wet areas when the table linen and padding were moved. In addition, suture material with tissue attached was identified on the floor in an OR room. In an interview on 11/28/17 at 10:40AM the O.R Attendant identifiedthe steps to clean an OR room in between cases includes mopping the floor for any visible soiled areas and when cleaning the table the surface must be exposed for 10minutes to allow for drying. Review of the OR cleaning policy identified that the cleaning solution needs to dry for at least 10 minutes.
   c. During tour of the O.R suite on 11/28/17 it was identified in O.R room 7 a three-liter intravenous (IV) bag of saline solution was located in the fluid/blanket warmer without an outer wrapper. In an interview on 11/28/17 at 1:10PM, the Director of Surgical Services identified the IV solution should not be kept in the fluid/blanket warmer and that there are other methods to warm the solution. The Director of Surgical Services also identified the outer wrapper serves as a protective cover and if removed the IV solution should be discarded if not used. Review of the Fluid/Blanket warming policy identified IV solutions should only be warmed using technology designed for this purpose.

# 2 a, b, c	
1.	*Meosures to prevent the recurrence of the identified violation, (e.g., policy/procedure, in-service program, repoirs, etc.)* 1. *Education and review of Surgicol Attire Policy during Dept. of Surgery Multidisciplinory Meeting completed on July 27, 2018* 2. *Review of the Operating Room Cleaning Policy with all Operating Room attendants on 6/27/18 with emphasis on all cleaning practices and removal of debris.* 3. *Trial of new cleoning product for the Operoting Room Suites with decreased drying time 7/2018.* 4. *Review of IV solution storage/disposal policy with Operating Room clinical staff 7/27/18.* 5. *Implementation of Environment of Core rounding of Operating Room Suites quarterly to ensure complionce with all identified findings.*
2.	*Date corrective measure will be effective:* • *Corrective measures were effective July 31, 2018*
3.	*Identify the plan to monitor corrective measure(s) or systemic change(s) to ensure thot the improvement(s) are sustained.* • *Implementation of Environment of Care rounding of Operating Room Suites by OR Charge Nurses with checklist.* • *Implementation of Environment of Care rounding by perioperative leadership monthly to ensure complionce with oll identified findings*
4.	*Identify the staff member, by title, who has been designated the responsibility for monitoring the individuol plan of correction submitted for each violation.* *Director of Surgical Services or Designee*

d. During tour of the telemetry unit (7 south) on 11/28/17 three glucometers were identified in the staff break room. One glucometer was located on the table near to personal staff food items and containers and was identified to have a blue colored stainacross the front of the device. In an interview on 11/28/17 at 10:00AM, Nurse Manager #12 identified that the glucometers should be cleaned after each use. In addition, Nurse Manager #12 identified that the unit has been temporarily located to 7 South for renovation purposes and that space has been limited to accommodate supplies and equipment.

#2D	
1.	***Measure to prevent the recurrence of the identified violation.*** • ***Glucometers were immediately removed from the staff break room and placed in a location where glucometers are stored. Education was provided to the staff to ensure cleansing and disinfecting as per Blood Glucose Monitoring Policy***
2.	***Date corrective measure will be effected.*** • ***Glucometers were removed from staff break room immediately (11/28/2017)*** • ***Education was done over a 1week period effective 12/10/2017*** • ***Weekly spot checks began 12/10/17 following the education.***
3.	***Identify the plan to monitor corrective measure(s) or systemic change(s) to ensure that the improvement(s) are sustained.*** • ***Weekly spot checks of glucometers are performed to ensure that they are being cleaned and disinfected according to Blood Glucose Monitoring Policy. Spot checks will have completed when compliance is 100% for a period of 6 months.***
4.	***Individual responsible for monitoring:*** • ***Nurse Manager, Telemetry***

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-03 (b) Administration (2) and/or (c) Medical Staff (2) and/or *(4) (A)* and/or (e) Nursing Services (1) and/or *(f)* Diagnostic and therapeutic facilities and/or *(i)* General *(6).*

3 **Based on clinical record review, facility documentation, interviews, and manufacturer instructions, for one of three sampled patients (Patient #14) reviewed for surgical procedures,the facility failed to ensure that equipment identified as being damaged was removed from circulation and not utilized during a surgical procedure. The finding includes:

a. Patient #14 was admitted to the ambulatory surgical unit on 10/4/17 for a transurethral resection of the prostate (TURP). Patient # 14 had a medical history that included bladder stones, hypertension, urolithiasis and osteoarthritis. Review of the Adverse Event report dated 10/4/17 identified during the TURP procedure MD#16 indicated the continuous flow pump was not functioning correctly. After the operating room (OR) staff corrected the fault the pump was able to function and the procedure continued. The report further identified after the procedure, P# 14 complained of epigastric pain while in the recovery room and was subsequently diagnosed with perforation of the bladder. P#14 underwent repair of the bladder perforation on 10/4/17 and was discharged home on 10/8/17. Facility investigation

identified the continuous flow pump was damaged prior to use and that tape was placed over the damaged area. No indicators were visible to identify wbo applied the tape.

In an interview on 12/5/17 at 9:25 AM, the Surgical Clinical Nursc Educator (RN #15) identified she relieved the OR staff for a break after P#14 had received a spinal anesthesia and was positioned for the procedure. RN # 15 identified she set up the continuous flow pump with another nurse and as the surgeon proceeded with the procedure he identified that there was a problem with the functioning of the pump. RN#15 identified the continuous flow pump's action is to allow fluid into the bladder and withdraw fluid as the prostate tissue is resected. RN #15 further identified the pump had tape attached to the front plate where tubing is threaded through but allowed thc pumpto be used since it appeared to be functioning after trouble-shooting the equipment. RN # 15 identified that the pump should have been taken out of service and sent for repair becausc of the visible damage and attached tape.

In an interview on 12/6/17 at 11:40 AM, the urologist MD #16 identified hc uses the continuous flow pump frequently and is very familiar with it. MD#16 identified prior tothe TURP procedure he asked the OR staff (travel nurse) if they were familiar with theset-up of the pump who confirmed that they were. MD#16 stated as he was doing the procedure air was being pushed into the bladder and the fluid irrigation was backing upinto the inflow irrigation tube. MD# 16 believed that the tubing was incorrectly connected to the pump and once this was corrected, he was able to continue with the procedure and able to visualize that the bladder was intact. MD#16 also identified thatP#14 had bladder diverticula and with a rccent history of bladder stone removal the additional pressure in the bladder during the procedure may have been cumulative factors for the bladder perforation.

Review of the continuous flow pump instruction manual identified in part that it is extremely important that the tubing be properly connected in the correct direction through the pump head.

#3a	
1.	***Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, in-service program, repairs, etc.)*** • ***Equipment removed immediately from service and retired. Loaner equipment issued by vendor for usage.*** • ***Education and training including tube connection for loaner equipment provided on 10/19/17*** • ***Review of the management of clinical medical equipment completed for Operating Room staff on 11/9/17.*** • ***SBAR provided for all organization associates on management of medical***

	equipment 11/2017. • *New equipment (pump) purchased and put into service 12/2017. Additional education not required. Replaced and loaner equipment are the same model.*
2.	*Date corrective measure will be effective:* *Corrective measures were effective 12/2017*
3.	*Identify the plan to monitor corrective measure(s) or systemic change(s) to ensure that the improvement(s) are sustained.* • *Tube connection steps eliminated secondary to new pump design.* • *Annual Medical Equipment Maintenance*
4.	*Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.* • *Director of Surgical Services or Designee*

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (6).

4. Based on clinical record review, facility documentation, interviews, and policy review, for one of three sampled patients (Patient #9) reviewed for falls, the facility failed to ensure that the fall protocol was implemented in accordance with facility policy. The finding includes:
   a. Patient (PT) #9 was admitted on 12/27/16 with a diagnosis of shortness of breath and pleural effusions. Patient #9's medical history included multiple mycloma, hypertension, depression and anxiety. Review of the clinical record dated 12/27/16 identified that the patient had a Hendrich score of six (6) indicating that the patient was at risk for falls. Interventions to the plan of care included, wheels locked, bed in low position, call device within reach, and upper half length side rails in the upward position for bed mobility. Clinical record review identified on 12/31/16 at 8:00AM, the patient's Hendrich score was 5, patient considered at risk to fall. Attempts to extubate PT#9 that morning was unsuccessful therefore, Propofol sedation continued. Review of facility documentation identified that on 12/31/18 at 2:30PM, the RN left PT#9's room and shortly thereafter the patient was found on the floor laying on his/her right side. The Trauma team responded and assessment identified ecchymosis to forehead; CT scan of brain, spine, chest and abdomen reported negative findings and no fracture. A high-risk fall management intervention plan of care was initiated post fall which included placement of a tab and bed alarm. Documentation further identified on 1/1/17 PT#9 was noted to have right side orbital hematoma, unequal pupils with right lateral eye deviation. A CT scan of the brain reported small right sided intraventricular hemorrhage (IVH),

subsequent neurology consult reported no surgical intervention required. On 1/2/17 the patient was successfully extubated and complained of right elbow pain, subsequent x-ray and orthopedic consult reported minimally displaced fracture of the right humerus; no surgical intervention required.

In an interview on 12/5/17 at 1:00PM, Nurse Manager (NM) #5 (the Clinical Nurse Leader of ICU) identified the fall protocol is initiated for Hendrich scale score of 5 or more with interventions such as raised side rails and bed alarm. NM #5 further identified that the fall protocol was not initiated on the admitting fall assessment which would include placing a bed alarm.

Review of the Fall Prevention policy directed that all patients, 18 years and older will be assessed for risk to fall using the Hendrich fall risk model assessment criteria, upon admission and at least once during an 8-hour shift. A score of 5 or greater indicates thatthe patient is a high fall risk and will be placed on the Ruby Slipper Fall Prevention Program. Interventions include but are not limited to the use of a removable bed/chair alarm.

#4a	
1.	***Measure to prevent the recurrence of the identified violntion.*** • ***Reinvigoration of fall signage as a visual cue for fall prevention*** • ***Story shared at safety huddles as well as review of Fall policy with focus on assessment upon admission and at least once during 8-hour shift.*** • ***Re-education regarding Hendrich II falls risk assessment completion, initiation of interdisciplinary Plans of Care (IPOC) and individualization of IPOCs*** • ***SBAR placed on source to heighten awareness of fall prevention including all possible interventions individualized to patient's presenting problems.***
2.	***Date corrective measure will be effected.*** • ***Above interventions and re-education: March 2017***
3.	***Identify the plan to monitor corrective measure(s) or systemic change(s) to ensure that the improvement(s) are sustained.*** • ***Audits of 10 charts per month for fall risk assessment completion every 8 hours, IPOC individualization.***
4.	***Individual responsible for monitoring:*** • ***Nurse Manager Critical Care***

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1).

5. Based on clinical record review, interview and policy review, for 3 of 20 records reviewed forpain (Patients #1, #14 and #16), the facility failed to ensure the patient's pain was reassessed todetermine the efficacy of the intervention. The findings include the following:
   a. Patient #1 presented to the ED on 4/22/18 at 7:32 PM after amputating the third distal phalange and partial amputation of the 2nd distal phalange on the left hand. The recordindicated that the patient rated pain level as a 10 on a scale of 0-10 (with 10 being theworst pain possible). The patient received 4 milligrams of Morphine intravenously at 7:49 PM, 8:16 PM and 8:40 PM. The record failed to reflect a reassessment of the patient's level of pain after the administration of medication. The patient rated pain as a 10 at 9:17 PM at which time Dilaudid 1 mg. IV was administered, however, the record failed to reflect a reassessment of the patient's pain level.
   b. Patient # 14 presented to the ED on 4/18/18 at 11:52 AM with a finger injury. The patient was seen in triage at 11:56 AM and rated pain as a 10 at 12:00 PM with Morphine 1 mg IV administered at 12:35 PM. The record failed to reflect that thepatient's level of pain was reassessed until 3:45 PM.
   c. Patient #16 presented to the ED on 4/17/18 at 8:49 AM with complaints of right hand swelling and cold to touch. The patient rated pain as a 9 at 8:50 AM. The record reflected that the patient did not receive pain medication until 10:13 AM (Fentanyl 50mcg intravenously). At 10:41 AM, the patient reported a pain level of 6 with Fentanyl 100 mcg IV administered at 11:13 AM. The record failed to reassess the patient's pain until 12:51 PM when the patient indicated his/her pain level was an 8. At 3:04 PM, the patient received Fentanyl 100 mcg IV however the record failed to reflect a reassessment of patient's pain level until 5:49PM at which time it was a 10.

      Interview with the Nurse Manager on 5/8/18 at 2:00 PM stated the patient's level of painshould have been reassessed in accordance with facility policy. Review of the policy indicated that the patient's pain level should be assessed every eight hours and 30-60 minutes post a pharmacological intervention. Thirty minutes for parentcral medication and 60 minutes for oral medication.

# 5 a, b, c	
1.	***Measures to prevent the recurrence of the identified issue af noncompliance, (e.g., palicy/pracedure, in-service program, repairs, etc.)*** ***1. Review fiudings in an ED Tawn Hall meeting*** ***2. Request clinical infarmatics team to place a request far the ED RN to be automatically tasked to reassess pain post pharmacalagical intervention.*** ***3. Request the ED praviders to arder pain medication as a prn order in lieu of "STAT." This will task the RN ta reassess pain.***
2.	***Date corrective measure or chauge is effective.*** ***1. July 27, 2018*** ***2. August 3, 2018 request placed.*** ***3. July 27, 2018***
3.	***Identify the plan to monitor corrective measure(s) or systemic change(s) to ensure that the impravement(s) are sustained.*** ***1. Audit 30 ED records a manth for compliance of the following:*** ***a. Pain reassessed within 60 minutes of a pharmacalagical intervention until campliance of 90% or better is achieved for a 3-month consecutive period.***
4.	***Identify the staff member by title who is responsible for ensuring compliance with the individual plan of correction submitted for each violation.*** ***Director of the Emergency Department***